

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>151509</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/14/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA UNIVERSITY HEALTH HOSPICE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>619 W 1ST ST BLOOMINGTON, IN 47403</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p><b>INITIAL COMMENTS</b></p> <p>This was the 2012 ISDH Food Protection Survey based on the Retail Food Establishment Sanitation Requirements at 410 IAC 7-24.</p> <p>Facility Number: 005811</p> <p>Survey Dates: 2/14/2012</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 15, 2012</p> <p>The Indiana University Health Hospice was in compliance with 410 IAC 7-24 Retail Food Establishment Sanitation Requirements during this survey.</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1